PARK EXPLORERS DAY CAMP
EMPLOYEE HEALTH RECORD

COMPLETE AND SIGN BELOW.

Name: _____ ____ _____ **DOB** ___ / ___ / ___ **sex male** ☐
First **MI** **Last** **female**☐

Address:_____ **SS#**_____ ___ _____

Home phone# _____ **cell phone#** _____ **email** _____

Hospital or Medical Insurance no ☐ **yes** ☐ Name of Carrier_____
(Please make a copy of your insurance card and attach.)
Name of policy holder_____

Person to be Notified in case of Emergency:

Person #1 _____ relationship _____phone#_____ Phone#_____

Person #2 _____ relationship _____phone#_____ Phone#_____

Person #3 _____ relationship _____phone#_____ Phone#_____

To BE FILLED OUT BY PHYSICIAN
Medical History (check √ and describe in remarks)

☐ **Rematic Fever**_____	☐ Convulsive Disorder _____
☐ **Heart Trouble**_____	☐ Gastointestinal Disorders_____
☐ **Kidney Trouble or urinary problem**_____	☐ Serious Injuries _____
☐ **Orthopedic problem**_____	☐ Treatment/Medication_____
☐ **Bronchitis or chronic cough**_____	☐ other diseases or conditions (list) _____
☐ **Diabetes**_____	_____
☐ **Allergy (incl. asthma)**_____	_____

Hospital Care,with cause: _____

Chronic or Recurring Illness or problems _____

Physical Exam: (check off if defect and decribe below)

☐ 1 Eyes	☐ 4. Mouth/throat	☐ 7 Neck/glands	☐ 10 Abdome	☐ 10 Neuromuscular
☐ 2. Ears	☐ 5. Skin	☐ 8. Heart	☐ 11. Hernia/Gentalia	
☐ 3 hearing	☐ 6. Teeth o	☐ 9. Lungs	☐ 12. Orthopedic	

Number _____ Discribe_____
_____

Immunization History This is a record of dates of basic immunizations and most recent booster doses.

DPaP, DTP or TD Date _____ Date _____ Date _____ Date _____ Date _____
Polio Date _____ Date _____ Date _____ Date _____ Date _____
MMR Date _____ Date _____ Date _____ Date _____ Date _____
Hemophilus Influenzae Type B Date _____ Date _____ Date _____ Date _____
Hepatitis B Date _____ Date _____ Date _____Varicella_____ Date _____
Other_____Date _____ Date _____

I hereby certify that I have examined _____ and found he/she is physically qualified for employment for lawful employment, being in sound health and of normal development or that he/she is in such condition as justifies the limited employment indicated.

Signatue of Physician_____ **Date**_____